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INVITED COMMENTARY

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In the first edition of Rutherford's Vascular Surgery, the potential impact of aortic surgery on postoperative sexual function was not even mentioned. Ralph DePalma rightly deserves credit for illuminating the problem of postoperative sexual dysfunction following aortoiliac operations, and for promoting techniques to prevent iatrogenic impotence. Over the past 30 years, vascular surgeons have learned to obtain an appropriate sexual history from their patients preoperatively and to forewarn patients of the risk of postoperative sexual dysfunction, at least in part, due to the threat of medicolegal retaliation. We recognize the importance of preserving blood flow to the internal iliac arteries and avoiding injury to the autonomic nerves flanking the aortoiliac bifurcation. Beyond these basic principles, however, we remain woefully ignorant of the impact of vascular surgery on sexual function.

Previous attempts to define the incidence of postoperative sexual dysfunction have generally been hampered by poor study design, the use of inadequate survey instruments, and societal attitudes barring frank discussions of sexual activity, especially among the elderly. Retrospective questionnaires regarding preoperative sexual performance have been shown to be notoriously inaccurate. Patients tend to glorify the "good old days" in the absence of objective measures.

In this prospective study of patients undergoing endovascular aneurysm repair (EVAR) or open aortic surgery, Peterson et al make several important observations. First, the majority of men had poor erectile function preoperatively. Similar findings of a high prevalence of preoperative sexual dysfunction in patients prior to either EVAR or open repair were also reported in the Dutch DREAM trial. Second, aneurysm surgery does not typically have a beneficial effect on sexual activity. At one year, more than 75% of all patients reported significant sexual dysfunction. Third, EVAR is no better than conventional surgery in preserving or enhancing sexual function. In fact, analyzing only those patients with preoperative interest in sexual activity, there was a statistical deterioration in the quality of erection and ability to achieve ejaculation in the EVAR group. Taken together, the DREAM trial and the present study strongly suggest that EVAR may have a significant impact on sexual performance. The mechanism by which EVAR affects sexual function is unknown. Finally, few patients reported receiving appropriate preoperative counseling regarding the potential impact of vascular surgery on their sexual function. While at first glance this would see to be an indictment of our Swedish surgical colleagues, it may also indicate that our elderly, anxious, and overly-stressed patients are more concerned with survival than sex.

There are some serious deficiencies in the present study. The study is based entirely on patient self-reporting. The EVAR patients were on average seven years older than the open repair group, which may account for the slight difference in sexual performance. There were too few women included in this study to make any broad conclusions other than to reinforce the need for more information regarding the sexual health of female vascular patients. Finally, there is a lack of anatomical or physiological data to compare with the subjective survey information. The authors provide little information regarding vascular anatomy, penile blood flow, or objective measures of sexual performance.

Despite these limitations, the present study serves to call our attention to the need for more rigorous study of sexual function in vascular patients. The finding that EVAR may not be preferable to open repair in preserving sexual function certainly raises important questions about our understanding of the complex factors that govern sexual activity in our elderly patients.